



Advising the Congress on Medicare issues

Medical education in the United States: supporting long-term delivery system reform

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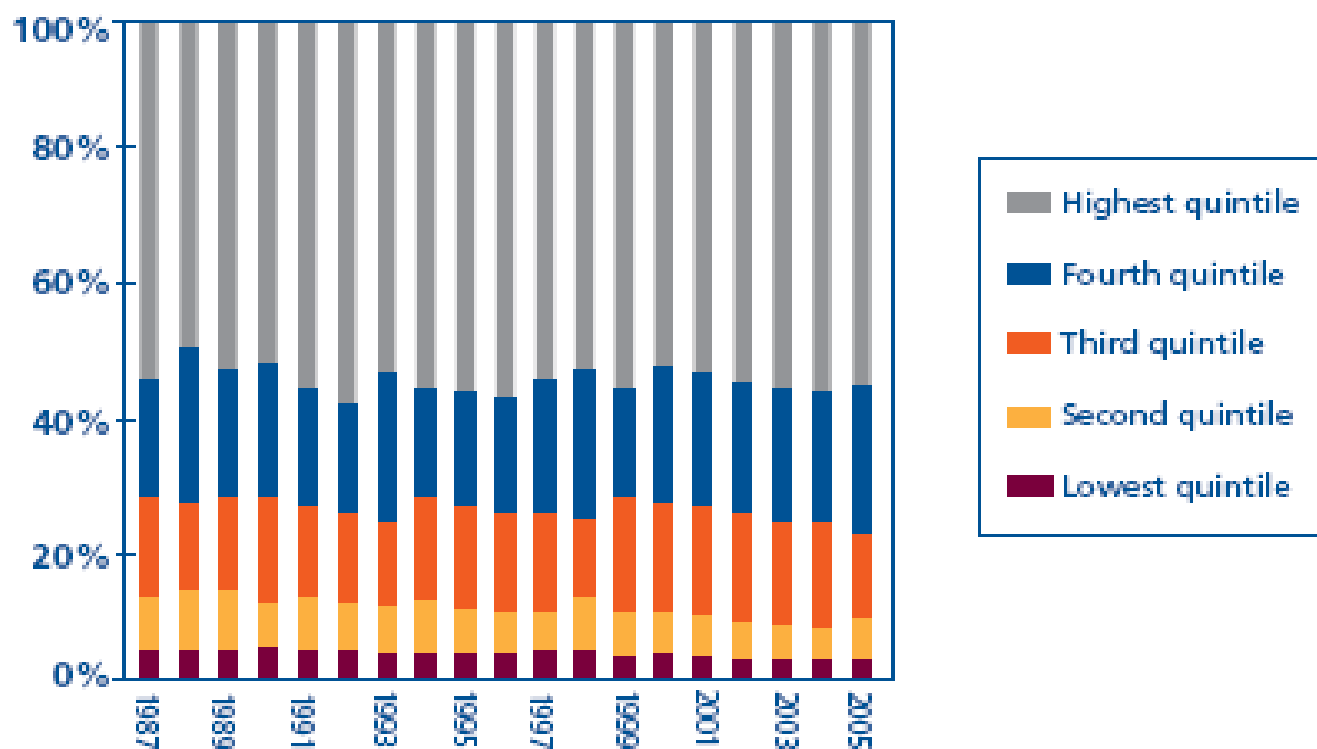
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Overview

- Review of details on questions from last presentation
 - Demographic data on medical school students
 - Part B payment rules for resident supervision
 - Economic costs and benefits of residency programs
- Discussion on future work

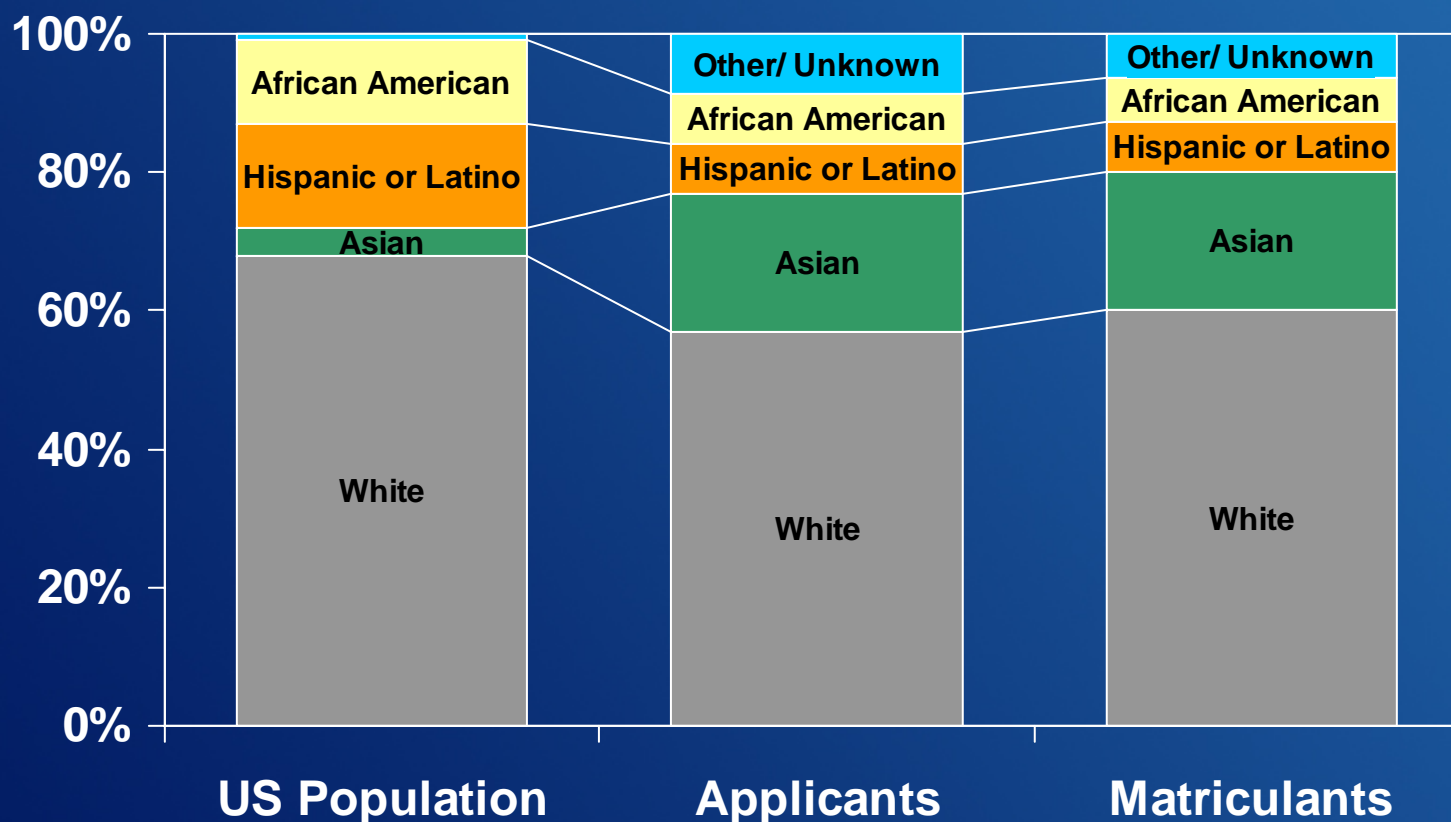
Most medical students come from higher income households

Figure 2. Parent Income of Entering Medical Students in U.S. Medical Schools, by Quintiles of U.S. Household Income, 1987-2005



Source: AAMC 2008, *Analysis in brief*, diversity of US medical students by parental income, Vol. 8 No. 1 January.

Racial composition of medical school applicants and matriculants



Source: AAMC and US Census data for 2007

Rules for Part B reimbursement for supervising physicians

- Supervising physician can bill for service provided by resident if:
 - Physically present for critical or key portions of service or actually performs service
 - Participates in the overall management of patient and
 - Documents their presence during service including who provided each portion of the service
- Exceptions on presence rule
 - Relaxed rules for low-level E&M services in primary care centers
 - Stricter rules for complex procedures

Economic costs and benefits of participating in teaching activities

Costs

- Compensation for residents and faculty
- Program overhead
- Facility infrastructure
 - Library
 - Office and on call space
 - Technology adoption
- Inefficient practice
 - Ordering more services
 - Taking longer to perform services
 - Documentation
- Attract more complex patients

Benefits

- Direct and indirect GME payments
- Residents' labor
 - Lower cost
 - More timely service delivery
 - On call coverage
- Prestige
 - Higher patient volume
 - Ability to garner higher prices
 - Academic affiliation
- Keeping current on research and technology
- Physician recruitment

Future work: analysis of specific policy options

- To increase non-hospital experience in residency training for certain specialties
 - Possible approaches:
 - Eliminate any unnecessary regulatory barriers
 - Reduce financial disincentives
 - Establish requirements for Medicare funding
- To improve residents' knowledge and skills for delivery system reforms
 - Possible approaches:
 - Encourage accrediting organizations (e.g., ACGME) to place greater emphasis on specific curricula in auditing process
 - Support research and programs to train-the-trainer
 - Establish curricula requirements or financial incentives for Medicare funding

Questions for discussion

- How should all payers explicitly contribute to medical education?
 - Equitable, efficient distribution of payments (e.g., trust fund, independent board)
- How can delivery system reforms be linked to the graduate medical education process?
 - Institutional incentives
 - Infrastructure (e.g., health IT)
 - Reformed payment policies (e.g., A/B bundling)
 - Curricula incentives (e.g., care-coordination, geriatric care)
- How can medical education subsidies help produce the professionals we need?
 - Residency subsidies for generalists (PCPs, NPs, PAs)
 - Loan forgiveness and demographic diversity programs
 - Minimal public service requirements for all physicians